States • of • Guernsey
BOARD OF
HEALTH

HEALTH FOR PEOPLE

WORKING TOWARDS A BETTER
HEALTHIER WAY OF LIFE

98th ANNUAL MOH REPORT

and

THIRD ANNUAL REPORT of the DIRECTOR OF PUBLIC HEALTH

Special Supplement:

"The Impact of Alcohol on Health in Guernsey"

REPORT FOR
THE YEAR 1996/97

STATES OF GUERNSEY

BOARD OF HEALTH

Objectives

To maintain and improve the health of the people of Guernsey and Alderney as cost effectively as possible by:

- Identifying health needs - now and in the future.
- Planning the future provision of health services to meet these needs.
- Ensuring that the quality of health services provided is high and standards are maintained through careful monitoring.
- Ensuring that only appropriate and effective care or treatment is given, by monitoring the outcome of such interventions.
- Informing people on health matters, promoting a healthy lifestyle and environment.
- Checking that all health services provided are as cost-efficient as possible.
- Promoting managerial and professional excellence within health services.
- Recruiting, training and developing sufficient health care staff to achieve these objectives.

BOARD OF HEALTH

MEMBERS 1996

President: Conseiller Mrs S M Plant

Vice President: Deputy B Russell

Senior Member: Mr G V F Birch

Other Members: Deputy O D Le Tissier
Deputy Mrs J Beaugeard
Deputy H R Allen
Deputy M Barrett

INTRODUCTORY LETTER TO THE BOARD OF HEALTH

October 1997

The President
States of Guernsey Board of Health

Madam President, Members of the Board

I have pleasure in submitting the 98th Annual Report of the Medical Officer of Health for Guernsey for 1996/1997.

I am, Madam
Your Obedient Servant

Dr David Jeffs
MEDICAL OFFICER OF HEALTH
Director of Public Health

CONTENTS

Board of Health Members 1996
Board of Health Objectives
Medical Officer of Health Introductory Letter
Highlights from this Report

1. "The Health of the Islands" 1996/97

Introduction

Lifestyle Related Diseases

- cigarette/tobacco related illness
- alcohol and health
- illicit and prescribed drugs
    - the need for a drugs strategy
- prescribed drugs
    - The "Medidump"
    - Kings Fund Review
- sexual health

Health and the Environment

- BSE and CJD
- *E Coli* 0157
- Ongoing Environmental and Energy problems
    - Liquid and Solid Waste Management
    - Traffic congestion
    - Housing and Energy problems

The "Greying of Guernsey"

- The Demographic Time bomb - is it real?
- Need for a Cancer Strategy
- Osteoporosis

Staff Health and Safety

2. The Public Health Importance of "Risk"

- Risk and Public Health
- "Life is a risky business......."
- The Language of Risk
- Confusing "Hazard" and "Risk"
- Perception and Acceptability of Risk
- Risk Management in a Health Setting
- A Model for Risk Communication and Management
- Risk - Conclusions, References and Further Reading

3. **Environmental Health**

- Introduction
- Complaints/ Requests for Advice/ Enquiries
- Food Safety and Infection Control
  - Food Complaints
  - Food Surrender
  - Food Education
  - Food poisoning
- Control of the Physical Environment
  - Water Sampling
  - Rodent and Pest control
  - Housing
  - Air Quality Monitoring

4. **Health Promotion**

- Introduction
- Infection
- Smoking
- Chronic Heart Disease
- Cancer
- Alcohol and Drugs
- Sexual Health
- Family Health
- Accident Prevention
- Mental Health
- Health Education for Schools and Young People
- Training
- Liaison
- Conclusion

5. **Communicable Disease Control**

- Communicable Diseases
- Infection Control
- Sexual Health
- Infection Control Committee

6. **Occupational Health and Safety**

- Occupational Health
- Fire Health and Safety
- Health & Safety Working Group

7. **Guernsey and Alderney - Vital Statistics 1996**

8. **Staff Providing Public Health Services 1996**

HIGHLIGHTS FROM THIS REPORT

- Once again it is most gratifying to be able to report that for the third consecutive year *"the health of Guernsey people, as measured by traditional indices, appears excellent"*.

- Notifications of infectious diseases are at an all-time low, and with the exception of "food poisoning", are no longer a significant cause of morbidity on the island. Life expectancy is high, and deaths from most major causes continue to decline.

- As the traditional causes of morbidity and mortality have declined, the so-called "diseases of affluence" have become of greater importance. Epidemiological studies suggest that personal exposure to known "risk factors" increases the likelihood of developing such diseases. Known risk factors include smoking, excessive alcohol consumption, unhealthy diet and illicit and prescribed drug misuse.

- The dual approach of promoting "informed choice" for the individual, whilst trying to ensure "healthy public policy" for the community underpins our public health strategy to reduce the impact and consequences of "lifestyle-related diseases" on the health of the populations of Guernsey and Alderney.

- Smoking-related diseases can be shown to be a major cause of preventable ill health and premature mortality. They are responsible for an estimated 110-130 deaths annually, in Guernsey - without doubt the largest single cause of preventable deaths in the Islands.

- Because most regular smokers have become addicted before early adulthood, the thrust of a rational smoking policy must be to make smoking less acceptable, less accessible, and less affordable to young people. A package of measures designed to achieve this has been progressively implemented since the States "Tobacco Debate" in July 1996.

- Alcohol, and the trade in alcohol have contributed to the prosperity in Guernsey and have been the central influence on the social history of the Island for at least three hundred years. Even today, tourism and tourism infrastructure (both of which are strongly alcohol-based) are important sources of employment and revenue.

- However, Guernsey must be described as a "wet culture". Annual levels of consumption at around 11 litres Pure Alcohol Equivalent (PAE) per capita are at the upper end of alcohol consumption in Western Europe, and only a little below France. The Guernsey *"Alcohol and Young Adults"* Survey suggests that many young adults of both sexes are already drinking at a level likely to damage their health.

- The "Population Theory" of alcohol consumption suggests that the extent of alcohol-related harm in a community will be proportional to the average per capita alcohol consumption.

- A greater benefit will derive to that community from moderating overall alcohol consumption than merely concentrating on a "High Risk" strategy to reduce alcohol related damage amongst the heaviest drinking section of the population.

- Not all influences on population drinking levels are under Guernsey's control. However, Guernsey is more fortunate than most communities in having many of the keys to effective action already in its possession. If the community accepts that alcohol consumption at present levels will have an adverse impact on many aspects of community life, then it will require both political will and popular support to bring about the necessary change.

- Along with tobacco and alcohol, Guernsey must also be seen to have the potential for a greater "illicit drugs" problem. To achieve the best mix of services to address this will require inter-departmental working to develop an appropriate "Drugs Strategy". Such a process is already being addressed.

- Prescribed drugs also have the potential for inappropriate use. This is a further area which must be tackled by joint action between the Board of Health, Guernsey Social Security Authority and prescribing Medical Practitioners.

- The value of collaborative inter-departmental working was also shown by successful efforts at co-ordinating approaches to control of BSE, and possible associated risks to human health through Cruzfeldt-Jacob Disease. This approach was also extended to ensure successful implementation of the Pennington Enquiry recommendations on *E Coli 0157* in Guernsey.

- The so-called "demographic time-bomb", brought about by an ageing populating is a cause of great public concern. The results of the 1996 Census shows that Guernsey has a lower percentage of population over 65 years than the UK, and many other European countries. The "demographic time-bomb" in Guernsey may be said to have a fairly long fuse.

- Nonetheless, there are issues which must be addressed now in order to prepare adequately for the eventual "greying of Guernsey". These include the development of a cancer strategy, and a rational approach to the prevention and management of osteoporosis across the population. It is intended that *"The Health of Older People"* will form the *"special theme"* of the 1997/98 Annual MOH Report.

- An understanding of the concepts of *risk, risk communication, and risk management* are important to the understanding of public health in general, and also to the individual disciplines of environmental health, health promotion, communicable disease control, sexual health, and occupational health and safety.

- These concepts are further explored in this Report. A framework is proposed to give clearer understanding and better communication of hazards which may pose threats to the health of the people of Guernsey and Alderney, both now and in the future.

Chapter 1

"The Health of the Islands" 1996/97

> *"To maintain and improve the health of the people of Guernsey and Alderney as cost effectively as possible........"*
>
> Primary Objective -
> Guernsey Board of Health

Introduction

Welcome to the 98th Annual Medical Officer of Health (MOH) Report, and the third Report of the Director of Public Health (DPH) for Guernsey.

Once again it is most gratifying to be able to report that for the third consecutive year *"the health of Guernsey people, as measured by traditional health indices, appears excellent"*.

Notifications of infectious diseases are at an historical all time low, and with the exception of "food poisoning" (of which more later), are no longer a significant cause of morbidity on the Island. Life expectancy is high, and deaths from most major causes continue to decline.

So where now should the Board of Health be focusing its resources to best achieve their objective *"to maintain and improve the health of the people of Guernsey and Alderney as cost effectively as possible.............?"*

Many topics of public health significance and importance are touched on in the body of this Report, and it is therefore difficult to select those particular aspects which seem to offer greater potential for personal health gain, or to provide wider benefits for the community from improvements in population health. But, if public health, at least in part, is about achieving the best health for the greatest number at the most affordable cost, then certain areas commend themselves for more-in-depth analysis.

This year I have chosen to highlight the following topics which I feel to be of particular significance or importance to the health of the islands.

Lifestyle Related Diseases

As traditional causes of morbidity and mortality have declined, the so-called "diseases of affluence" have become of greater importance. Epidemiological studies suggest that personal exposure to known "risk factors" increases the likelihood of developing such diseases.

There is thus an element of personal choice in the degree to which we choose to expose ourselves (or to avoid) known risk factors such as smoking, excessive alcohol consumption, unhealthy diets, and illicit and prescribed drug misuse.

Part of the role of Public Health, shared with the other health professions and with the media must therefore be to ensure that the public is sufficiently aware of known risk factors that people can make an "informed choice" as to their degree of exposure.

However, it is obviously wrong to always "blame the victim" for the development of lifestyle related diseases. It is unreasonable to expect people, especially the less affluent, to choose healthy alternatives when less healthy choices are more accessible and less expensive.

Thus the complementary role of public health must be to ensure that there is "healthy public policy" at every level of government and that "healthy choices" become "easy choices," accessible to the whole population.

This dual approach of promoting "informed choice," for the individual, whilst trying to ensure "healthy public policy" for the community underpins our public health strategy to reduce the impact and consequences of "lifestyle related diseases" on the health of the populations of Guernsey and Alderney.

- **Cigarette/Tobacco Related Illness**

  A good example of this dual approach is illustrated by our progress with tobacco control during 1996/97.

  The Government White Paper "The Heath Of The Nation" claimed in 1992 that *"Smoking remains the largest single cause of preventative mortality in England"*. All local evidence suggests that tobacco related illness is an equal or greater problem in Guernsey, with more affordable cigarettes, a greater proportion of young people smoking, higher levels of smoking amongst those who do smoke, and higher cigarette related mortality over a five year period for both men and women when compared with their counterparts in England. Smoking related diseases can be shown to be responsible for between 110 and 130 deaths annually in Guernsey.

  Recognising the importance and potential benefits of reducing tobacco related illness on the islands, the Board of Health has supported and developed an integrated and co-ordinated Tobacco Strategy, culminating in a Policy Letter on "The Impact of Advertising and Duty on Alcohol and Tobacco Consumption in Guernsey", which was debated by the States of Deliberation in June 1996.

  Given the overwhelming evidence on the adverse health consequences of cigarette smoking, after a lengthy and sometimes heated debate, the States agreed to support all the Board of Health propositions, the effect of which will be to:-

  - introduce a total ban on all public advertising of tobacco and tobacco products except a point of sale. Imported print media will be exempt.

  - increase the size and content of pack warnings as originally proposed in the Draft Voluntary Agreement on Tobacco Advertising;

- amend the 1913 Tobacco Ordinance to raise the minimum age for the legal purchase or possession of cigarettes and tobacco products from 16 to 18 years; and to restrict purchases from cigarette vending machines.

- increase the level of duty on tobacco and tobacco products by a minimum of £20 per kilo from 1 January 1997;

- additionally, increase the level of duty on tobacco and tobacco products by at least 8.5% per annum in real terms in future budgets for a minimum of five years commencing 1 January 1998;

- maintain and increase a range of Health Promotion activities designed to help addicted smokers break their addiction, to support school and community based programmes designed to discourage young people from smoking, and to promote a better healthier way of life generally.

Implementation of these strategies has proceeded steadily since the States have voted their support. The success of this package of proposals in reducing smoking levels, especially amongst the young, will be tested in the school based "Health Related Behaviour Survey", which is planned across all island Secondary schools in late 1997, and the postal "Health Lifestyle Survey" to be conducted across a sample of approximately 1000 Guernsey adults, randomly selected from Family Practice Lists, which will take place during 1998.

Meanwhile, efforts to ensure that the population are fully aware of the adverse health consequences of smoking, that there is help for the addicted who wish to reduce or give up, and these are complemented by public policy measures such as raising the level of excise, and increasing the legal age of purchase.

- **Alcohol and Health**

  The 1996 Policy Letter on Tobacco and Alcohol stated *"there is a large body of well researched scientific study to demonstrate the relative risks of various diseases which have been linked with smoking, and to the benefits of restricting advertising and increasing price as effective ways of helping reduce smoking rates, and their associated health consequences......... the position is less clear concerning alcohol"*

  Although the mortality associated with alcohol consumption in Guernsey is reported at only about one tenth of that known to be linked to tobacco smoking, there are undoubtedly huge additional adverse health and social costs, which are not reflected in the mortality statistics.

  In terms of public health strategy, our objective must therefore be to discourage the use of tobacco, and the abuse of alcohol. To formulate "evidence based" health policy in this area, it is crucial that we know much more about what influences Guernsey drinkers in their choice of drink, patterns of drinking and levels of consumption.

There are sufficient differences between income levels, the relative price of alcohol, leisure activities, and several other variables between Guernsey and the UK to need to research these factors in a Guernsey context.

The social impact and health consequences of alcohol on population health in Guernsey forms the "special theme" of this year's Annual Report, considered in greater detail in the special "Alcohol" Supplement.

- **Illicit and Prescribed Drugs**

Although estimates of numbers may vary, most informed observers would agree that Guernsey does not have a major drugs problem at present, and this impression is confirmed by data from the Wessex Drugs Misuse Database, to which workers in the drugs field should make regular returns.

The picture would seem to be one of a few regular drug abusers, a larger number of "opportunistic" hard drug users, and a wider degree of "experimentation" amongst young persons.

However, Guernsey does have all the ingredients for a potentially much larger drugs problem;

- a relatively young affluent population profile
- a perception of "nothing for young people to do" and "boredom"
- a travelling business community
- lots of private and visiting boats, yachts and planes

Experience elsewhere has shown that tough policing and tough penalties alone do not work in the longer term - if the demand is there, then scarcity will lead to higher prices which in turn makes it worth taking greater risks to supply this demand.

How best to minimise the harm to personal health, societal damage and cost to the community inherent in widespread drug abuse requires the right mix of services for a particular community, working in a co-ordinated way. Such services must include;

- education on the dangers of drug abuse for the whole community, and for specific groups within it.

- adequate intelligence linked to effective supply reduction.

- appropriate levels of enforcement

- appropriate sentencing policies, linked with understanding and opportunities for treatment within the prison and probation services.

- "harm minimisation" facilities in the community

- adequate treatment and rehabilitation services

The responsibility for the effective provision of such a range of services obviously extends across several States committees and community groups. To ensure that the right mix of services is delivered in the most co-ordinated and effective way is beyond the remit of any single body.

At present, a co-ordinating function occurs through the Board of Health's "Dependency Sub-Committee," and also in the forum provided through by "Drug Concern".

The Need for a Drugs Strategy

The need for co-ordinated action has also been recognised in other jurisdictions. In England, the Department of Health published *"Tackling Drugs Together"* in 1995, whilst in our sister Channel Island of Jersey, a Report on the *"The Misuse of Drugs - a Combined Approach"* was also published in 1995, followed by *"Working Together Against Drugs - a Strategy and Implementation Plan"* in 1996. All these publications suggest the need for a more structured approach across agencies.

It was therefore agreed that the Board of Health's Dependency Sub-Committee should form a number of working groups to examine these documents and consider whether any of the approaches advocated were of potential value in tackling the drugs problem in the Guernsey context.

Working parties were formed, and issues examined across the following areas:

- education and prevention
- supply reduction and enforcement
- treatment and rehabilitation

A major finding to come out of all groups was that although Guernsey had much effective action in various areas of drug abuse control, it could not be said to have an overall "drugs strategy" - a systematic review of present services, identification of deficiencies, and a structured approach to overcoming these within a defined time frame.

Work is therefore continuing to identify a clearer strategic direction, and develop the right mix of services to best balance minimising harm to the individual whilst protecting society from the damage associated with drug abuse.

- **Prescribed Drugs**

There is a perception by the public, often shared in official circles, that the "drug problem" is almost exclusively about the misuse of "illicit drugs". Evidence would suggest however that in the Guernsey context, inappropriate use of "prescribed medication" is also a significant problem. The two are inter-related - when enforcement services are effective in reducing the import of "illicit drugs" then the misuse of prescribed medications tends to escalate.

The "Medidump"

The large amount of unused prescribed medication available in the Community is confirmed by the results of the "Medidump" organised early in 1997 by the Rotary Club of Guernsey in collaboration with community pharmacists, family practitioners and the Board of Health's Environmental Health Department. Almost 30 sacks of prescribed and "over the counter" medication were collected during the one week - much of it with the potential for causing serious harm to children or the elderly if taken inadvertently, or for abuse as "street drugs" if misappropriated.

Kings Fund Review

The Guernsey Social Security Authority also commissioned the Kings Fund to conduct a review of pharmaceutical services in Guernsey and Alderney during 1996. An interim report was published in March 1997, which suggested that levels of prescribing were higher per capita in Guernsey compared with the equivalent populations in the UK.

How much of this may be inappropriate will no doubt be debated following the release of the final Report. However the borders between the abuse of "illicit" and "prescribed" medication undoubtedly overlap, and more targeted prescribing must be one component of an overall approach to minimising drug related harm in Guernsey.

- **Sexual Health**

  Another area where personal choice can reduce the risks of adverse health consequences such as unwanted pregnancy and sexually transmitted disease is in the field of sexual health. This issue was highlighted during the States debate on "Contraception, Unplanned Pregnancy and Abortion," in June 1996. A range of measures designed to reduce the risks of unplanned pregnancy were supported, along with the decision to legalise abortion in Guernsey, if the circumstances met the strictly defined criteria contained in the new Law.

  Measures to help reduce the risks of unwanted pregnancy and sexually transmitted diseases include extra resourcing for Personal, Social and Health Education in island schools through the appointment of an additional Complementary Health Educator, improving access to barrier contraception and supporting the further development of the Guernsey Family Planning Clinic, who now wish to target their services more towards the younger age group.

  Sexual health is obviously an area of increasing importance, and one where there are obvious opportunities for a more co-ordinated and integrated approach between the various agencies involved.

Health and the Environment

It can truly be said that *"there can be no true personal health in an unhealthy environment"*. Identifying and reducing risks to health from adverse environmental factors has been a traditional and important part of the public health approach since the last century.

Newly identified transmissible agents such as the "prion" believed to be associated with Bovine Spongiform Encephalopathy (BSE) in cattle, known organisms of increased virulence such as the *Ecoli* 0157 associated with a large outbreak of food poisoning in Scotland, and much "unfinished business" in ensuring the most positive links between the environment and human health in Guernsey attest to the continuing importance of this area of Public Health.

- **BSE and CJD**

  The possibility that a transmissible agent known as a "prion" ("protease resistant protein") might be responsible for Bovine Spongiform Encephalopothy (or "Mad Cow Disease") was first proposed in 1986, and led to a requirement for the notification and slaughter of such animals in 1988 and a ban on "Specified Bovine Offal" (SBO) in 1990. The BSE epidemic peaked amongst cattle in 1992, and there has been a year by year fall in cases since then. An unexplained increase in the incidence of an apparently new variant of Creutzfeldt-Jakob Disease (v-CJD) in younger age groups than previously noted and presenting with more psychiatric and fewer neurological symptoms was noted in 1996. Several cases were associated with farm workers or their families, which suggested the possibility of interspecies transmissibility of the BSE prion.

  It was obviously essential, that strict measures to exclude bovine neurological material, and ensure that only meat from cattle under 30 months of age (the lower age limit for the development of BSE) were allowed to enter the human foodchain, and regulations to this effect were implemented in the UK, and endorsed by the European Union in 1996.

  The incidence of BSE is approximately ten times greater amongst dairy cattle than amongst beef cattle, probably due to the greater use of cattlefeed from animal sources, in dairy herds, and as a consequence, rates of BSE in the Channel Islands were amongst the highest in Europe, second only to the UK.

  The potential risks to population health in Guernsey obviously required swift and effective action, and the formation of a inter-departmental BSE Focus Group comprising the Director of Public Health, Chief and Deputy Chief Environmental Health Officers, States Veterinary Surgeons from both Guernsey and Alderney, and the Agricultural Advisory Officer of the Agriculture and Milk Marketing Board was effective in ensuring a consistent approach to protecting the human food chain, and ensuring the safe disposal of "cull cattle", initially through the export of carcasses for incineration and later by local incineration of cull cattle from both islands in Guernsey.

- ***E-Coli* 0157**

The potential for known organisms to achieve a greater virulence was illustrated by the much publicised outbreak of *E-Coli* 0157 in Scotland in late 1996 which affected almost 500 people, and is believed to have caused at least 18 deaths - the second highest number of deaths associated with an outbreak of *E-Coli* 0157 infection in health history.

The subsequent Pennington Enquiry identified contamination of cooked meat from affected raw meat as the most likely source of infection. Their final Report contained over thirty separate recommendations which were designed to reduce the risk of *E-Coli* 0157 infection on farms, amongst farmers and farm workers, in slaughter houses, in meat production premises and butchers shops, and at points of consumption. The Report also outlines proposals for improved surveillance, enforcement and the handling and control of outbreaks.

The value of a small local "expert group," which had already proved successful in co-ordinating measures to protect against BSE has proved equally valuable in ensuring effective implementation of the Pennington recommendations in both Guernsey and Alderney.

- **Ongoing Environmental Concerns**

The traditional role of Public Health in seeking to minimise the impact of adverse environmental factors on human health has already been mentioned. Unfortunately, appropriate remedial action often lies outside the accepted Health Authority mandate.

Therefore the new emphasis on encouraging the development of consistent environmental policy across States Committees foreshadowed in the 1996 Policy Planning Report, and reaffirmed in the draft Strategic Policy Statement on the Environment in the 1997 Policy and Resources Planning Report is to be welcomed.

Particular areas which impact on health, and where the Public Health perspective must help guide the eventual solution include:

- Liquid and Solid-Waste Management

Currently being addressed through the Advisory and Finance Committees Waste Strategy assessment to which the Environmental Health has been contributing.

- Traffic Congestion

This contributes to air and noise pollution, causes traffic accidents and related injuries, deterioration of the physical environment, and the discouragement of other forms of physical activity such as walking and cycling.
The development of a "traffic strategy" to encourage the optimum mix of public transport, private motor vehicle and other means of transport to protect both human health and the environment must be addressed as a priority, if present adverse trends are to be reversed.

- Housing and Energy Policies

The need for new housing to meet the needs of Guernsey's changing family structures and social expectations should not divert attention from the large amount of older, energy inefficient and unsuitable residential property which continues to exist as part of the Island's housing stock, particularly in urban areas. Support by the Advisory and Finance Committee for more "sustainable development" in Guernsey must encourage proper energy conservation standards in new housing, and support appropriate upgrading or replacement of existing housing to ensure energy standards which will best protect human health, and promote energy saving, energy conservation, and lead to the least energy wastage to the environment.

The "Greying of Guernsey"

Most people are aware of increasing life expectancy, and many have concerns about what effect this will have on the future provision of health and social services. Of particular importance is what action is necessary now, in order to minimise the likely health consequences of an ageing population in the next century.

- **The Demographic Time Bomb - Is it real?**

Despite public perceptions of a rapidly ageing population, results of the 1996 Census confirms that only 15.7% of Guernsey's population is currently over 65 years, compared with 17.2% above retirement age in the UK, and with even higher levels in several European countries.

Population projections suggests that the numbers of Guernsey residents over 65 years of age as a proportion of the total population will actually decline for at least the next 10 years, and not reach 1991 levels again until around the year 2011. In the Guernsey context, the "demographic time bomb" may be real enough, but it does have a fairly long fuse.

There is the need to use this longer lead time to plan and implement the best mix of health and support services to meet the likely health needs of older residents when this time comes.

It is intended that *"The Health of Older People"* should form the "special theme" of the 1997/98 Annual MOH Report.

- **Need for a Cancer Strategy**

70% of all cancers occur in people older than 60 years old. One consequence of an ageing population is the need to develop a Cancer Strategy to provide the best mix of services between Guernsey and UK Centres to ensure optimum outcomes for the predicted increase in various cancers. Initial results from the Channel Island Cancer Registry, which commenced collection in January 1996 are published for the first time in Chapter 8.

- **Osteoporosis**

Osteoporosis is a common and perhaps inevitable accompaniment of ageing in both sexes. Thin bones and increased risks of falls and other predictable accidents can lead to fractures, prolonged periods of hospitalisation, and often irreversible morbidity. Research suggests that effective prevention needs to start several decades before reaching the age where the risk of fractures is highest. The promotion of adequate calcium intake, hormone replacement therapy and sensible exercise routines amongst Guernsey women who are now approaching the menopause will undoubtedly reduce the development of osteoporosis and possible fractures on a population basis in the future.

The development of services and equipment for better diagnosis, and the most appropriate use of newer "bone building" drugs designed to combat osteoporosis need evaluating in the Guernsey context, as part of an overall "osteoporosis strategy". The self-help "Osteoporosis Society" established in Guernsey during 1996 obviously has a key contribution to make by raising public awareness in this important area.

Staff Health and Safety

The need for a healthy, well motivated workforce is essential if the Board of Health is to achieve its primary objective cited as heading to this Chapter. There has been much progress in both Occupational Health and Staff Health and Safety during the year, which is summarised in Chapter 6.

The move towards a more proactive "risk management" approach in various aspects of the Board's activities will play an important part in ensuring the highest reasonably achievable standards of health and safety across worksite, work practise, and patient care.

Chapter 2

The Public Health Importance of "Risk"

A unifying theme across the various facets of public health activity described in this Report is the concept of *"risk"*. Having read thus far, an enquiring Guernsey resident might well ask;

- What is the *risk* of my developing lung cancer if I smoke 10 cigarettes a day?
- What is the *risk* of my developing alcohol related health damage if I choose to drink in excess of the recommended "safe and sensible" weekly limit of 21 units if I am female, or 28 units if I am male?
- What are the *risks* of my developing nv-CJD if I continue to eat beefburgers?
- What are the *risks* of my child's asthma getting worse if traffic congestion and air pollution in Guernsey get worse?

These are all relevant questions, both to those who wish to safeguard their own health, and to those who care about wider health issues. One function of Public Health must be to provide informative and understandable answers, both to assist "informed choice" for the individual, and to guide "public policy" for the community.

Nearly everyone has heard of *"risk"* - indeed it would be unusual for the pages of most daily newspapers not to contain at least one new "risk" story. Far fewer people actually understand the epidemiological concept of *risk*. The communication of a better understanding of true levels of risk is central to effective public health practice. It is also that aspect of public health which is least well communicated by the media, and least well understood by the Public.

So important are the concepts of *risk, risk communication*, and *risk management* to public health in general, and to the individual disciplines of environmental health, health promotion, communicable disease control, sexual health, and occupational health and safety, that the remainder of this Chapter will be devoted to a more in-depth consideration of these concepts.

"Life is a risky business ......"

We are exposed to *risk* from the moment of our conception.

If our mother contracts an infectious disease during her pregnancy, then the *risk* of an adverse pregnancy outcome increases several-fold, depending on the particular infection.

There is no such thing as zero risk - absolute safety. There are *"risks"* associated with being born, with learning to walk, playing sport, driving a motor car, or going away on holiday.

Some of these *risks* are *avoidable* - we can exercise an element of choice by (for example) cancelling our holiday and staying at home, thus avoiding the *risks* of travel. Many other risks however will be, almost by definition - unavoidable.

We may consider many risks to be *"acceptable"*. We may judge, for example, that the risks of travel are very small, and the benefits of going on holiday are very large in comparison, far outweighing these perceived risks. Some people may consider some risks acceptable e.g. travelling by train, whilst other risks e.g. travelling by plane are *unacceptable*.

Depending on our own value system, risks may be seen as *justifiable*, or as *unjustifiable*. For example, a doctor may feel it is *justifiable* to prescribe a particular drug with known side effects, because he feels that the *benefits* of treatment far outweigh the *risk* of side-effects.

It can be seen therefore that to understand *risk*, it is first necessary understand the vocabulary of risk.

The Language of Risk

"Risk" has been defined as the *"possibility of incurring misfortune or loss"*. Expressed symbolically;

***Risk* (R) = *Hazard* (H) x *Probability* (P) x *Exposure* (E)**

"Hazard" has been defined variously as *"a set of circumstances which may have adverse consequences"* and *"exposure or vulnerability to injury or loss"*.

A *hazard* is therefore a *potential risk.*

"Exposure" in the epidemiological sense is the length of time we remain at risk from a particular hazard, whilst ***"probability"*** is a measure of the relative frequency or likelihood of occurrence i.e. a hazard (or potential risk) leading to an actual misfortune or loss.

Probability is normally expressed as the probability of a particular risk occurring to an individual (e.g. 1:1,000) - it does not say whether this will or not affect a particular person. For example, knowing that a forty year old has a 1:850 chance of dying from all or any natural cause during the succeeding twelve months does not help that individual to plan their life with greater certainty, although from a public health and actuarial point of view, it is a statistic of some importance.

Alternatively, *probability* may be expressed as a *"lifetime risk"* - for example, women in Guernsey have a one in twelve *lifetime* risk of developing breast cancer.

Further concepts which should be understood are those of *relative risk* and *absolute risk*. This was illustrated during 1996 when a "health scare" that certain formulations of the contraceptive pill doubled the risk of venous thrombosis, when compared with other "second generation" combined oral contraceptives became headline news.

Because the *absolute risk* of venous thrombosis from using the contraceptive pill is very small, even a doubling of this very small risk does not materially affect the absolute risk, which certainly still remains much less than the risks of suffering a venous thrombosis during pregnancy.

However, despite attempts at reassurance by public health authorities in England, many women opted to stop taking the pill altogether because of the perceived risks of thrombosis, and as a consequence, ran the far greater risk of becoming pregnant, with the much increased chance of venous thrombosis during pregnancy.

Confusing "Hazard" and "Risk"

An important part of *risk communication* is therefore about addressing people's *perceptions*.

Perception of risk is obviously influenced by our understanding (or lack of this). The major problem would seem to be one of confusing *hazard* with *risk*.

In the above example, the *hazards* of venous thrombosis were real enough, but since they were extremely unlikely to occur, the *actual risks* were almost certainly much lower than the alternative risks associated with becoming pregnant.

The world is full of *hazards* e.g. being struck by lightening or being killed in an air crash, but because *exposure* is limited, and the *probability* of an adverse outcome is extremely unlikely, then *objective risk* is very low indeed.

Electric storms are comparatively rare in Guernsey, and it is extremely unlikely that we would be standing on exposed ground during such electrical activity. Each year on average, only 6 people are killed by lightening strikes in Britain. And because *"exposure"* is so low, on this basis we could calculate that we would only expect one death from lightening strike once about every 166 years in Guernsey.

Similarly, the *probability* of an adverse outcome may be extremely low. It has been calculated that an individual would need to make at least ten million flights in a commercial jet aeroplane before dying in an aircrash.

Why then, do people get extremely concerned about risks from extremely unlikely events, whilst happily appearing to accept the far greater statistical probability of an adverse outcome from more mundane and common place occurrences?

Perception and Acceptability of Risk

Several possible reasons to help explain this confusion between *"Hazard"* and *"Risk"*, and the consequent difficulties in communicating true levels of risk will be considered.

The first relates to the nature of *"Hazard"*.

In an increasingly complex and technological world, many hazards will, by their nature, be new and unfamiliar. Because they have not yet caused any "injury or loss", but are perceived to have the ability to do so, the probability of this occurring must at best be an informed estimate. The understanding of the *"hazard"*, and the calculation of the *"risk"* will be undertaken by "experts" and generally expressed in statistical terms.

The general public however, frequently tends to distrust "experts" (especially technical ones), and has an even greater distrust of statistics. It may therefore find difficulty in accepting these assessments.

The second reason for this difficulty in risk communication lies in the wide spectrum of understanding and acceptance of risk.

Management texts have long divided people into *"risk takers"* and *"risk avoiders"*. Our view of risk is strongly influenced by personal opinion and social context. A great deal of argument about risk is not so much about objective measurements of hazards and disease risks, as it is about differing moral and social perspectives.

Whilst experts like to use statistics, most other people base their perceptions of risk on a very wide variety of other values, philosophies, concepts and calculations. This has clear relevance to predicting how people may respond to new hazards.

People (non-experts) generally tend to overestimate rare causes of mortality, and underestimate common ones. Comparatively rare causes of death such as being struck by lightning or being killed in an air crash are overestimated, because they are considered "newsworthy" and have been widely reported in the media. In contrast, more common causes of death (such as dying from heart disease) are significantly underestimated, because they are so commonplace as to have little "news value".

Another factor influencing people's perception of risk is its "perceived benefit". It has been found that most people are willing to accept risks from voluntary activities (such as skiing) roughly a thousand times greater than they would tolerate from involuntarily imposed hazards.

A fourth factor which influences people's perception of risk is the way this is expressed or communicated. It has been suggested that people are more prepared to undergo an operation with a 90% "survival rate", rather than one with a 10% "mortality rate" - although these of course are both the same things.

The American *"risk communicator"* Dr Peter Sandman has studied those factors which influence the *"acceptability of risk"* in some detail. He has concluded that

- Risks will be more readily accepted if voluntary rather than imposed.
- If they are perceived as "natural" rather than man-made.
- If they are familiar (e.g. heart disease) rather than "exotic" (e.g. shark attack).
- If they are chronic (e.g. the effects of cigarette smoking) rather than "catastrophic" (e.g. toxic chemical spill).
- If they are regarded as fair as opposed to unfair (the "moral framework").
- If a person is in control (driving your own car) rather than someone else in control (being the victim of an aircrash).

Such a wider understanding must influence the way we should approach risk communication. Although acceptance of a risk is for most people a value judgement, increased access to factual information can change perceptions of risk, and can therefore affect the acceptance of that risk.

Risk Management in a Health Setting

Most of the last vestiges of Crown Immunity for NHS Trusts were removed in 1991. This, together with an increasing willingness by the public to seek legal redress for perceived injury and loss, has led to a huge increase and interest in "risk management" in NHS Trusts.

The impact of these new approaches is already being felt in Guernsey and a more proactive approach to risk management will undoubtedly have a strong influence on the way the Board manages patient care, staff health and safety, and many other aspects of the Board's activities.

Risk management in a health setting has been defined as a proactive approach which;

- Addresses the various activities of an organisation
- Identifies the risks that exist
- Assesses those risks for potential frequency and severity
- Eliminates the risks that can be eliminated
- Reduces the effect of those which cannot be eliminated
- Puts into place financial mechanisms to absorb the financial cost of the risks which remain.

With the exception of the last point, this may be seen as a cycle of risk identification↔risk analysis↔risk control↔(new) risk identification.

However, the perception of risk varies between individuals, and between the "public" and the "expert". This is of particular importance in a health care setting, where "shopfloor representatives" may consequently have a very different perspective on the risks they face, compared with the objective risks as calculated by "experts".

Because all risk management carries both a resource and financial cost to the organisation, the question must still arise, how small must a risk be before it is no longer justifiable to invest public funds in its management?

For a few already tiny risks, it may be the case that they can be reduced even further at very low costs, but inevitably at some point there will be reached a situation where to reduce risk further will necessitate unjustifiable expenditure.

A Model for Risk Communication and Management

In his Annual Report *"On the State of the Public Health - 1995"*, Chief Medical Officer, Sir Kenneth Calman, has also explored various aspects of risk.

The model he proposes is equally valid for Guernsey, and for both communicating and understanding health risk (eg smoking and alcohol), environmental risk, (eg BSE or pollution-related asthma) or risk management in a health setting (eg environmental glutaraldehyde or asbestos).

The model proposed divides risk as follows:-

- **"Remote"** or **"Insignificant"** - a risk of an individual dying in any one year of less than 1:1,000,000, eg, being hit by lightning.
- **"Minimal"** - the risk of an individual dying in any one year of between 1:100,000-1:1,000,000, eg, killed in a railway accident
- **"Very Low"** - the risk of an individual dying in any one year of between 1:10,000-100,000, eg, being a victim of homicide
- **"Low"** - risks between 1:1,000-1:10,000, eg, dying in a road accident
- **"Moderate"** - risks between 1:100-1:1,000, eg, smoking 10 cigarettes a day
- **"High"** - greater than 1:100. The risks of death or adverse reaction at this level would be regarded as unacceptable, whether voluntarily or involuntarily undertaken

It should be noted that the above risk assessments are taken from UK figures - the risks of death from lightning strike, homicide, or road accident will almost certainly be much less in Guernsey.

Risk - Conclusions

In future years, as in the past, it is likely that new hazards will be identified, and old hazards will be re-assessed. These may include environmental hazards, communicable diseases, self-imposed and work-related risks. In every case, the public is likely to demand a clearer understanding of how such hazards are likely to impact on their health in Guernsey.

It is hoped that this Chapter will serve as a reference point, and provide a consistent framework for understanding present hazards, and reacting to such new ones as may become apparent in the future.

References and Further Reading

British Medical Association - *"The BMA Guide to Living with Risk"*
BMA 1990 ISBN 0 14 012504 3;

Adams J, *"Risk"*
UCL Press, 1995 ISBN 1 85728 057 9HB

Sandman, P.M, *"Responding to Community Outrage:- Strategies for Effective Risk Communication"* American Environmental Hygiene Association ISBN 0 932627 31X

Department of Health *"On the State of the Public Health"*
HMSO London, 1996 - ISBN 0 11 321989 X

Chapter 3

Environmental Health Department

Introduction

The reduction in the number of complaints/requests/enquiries during the year (see details below) was perhaps fortunate for the Department as the promotion of one of the Environmental Health Officers to the post of Administration Director to the Board of Health meant that the Department was seriously understaffed for most of the year.

The introduction of the *Registration of Food Premises Order;* the ongoing development of the Board's Waste Regulatory Authority role and the increased individual responsibilities undertaken by the remaining officers meant that they worked, at times, under extreme pressure. They are to be complimented on their continued professionalism and dedication to duty.

It was December before a local environmental health officer was appointed to bring the Department back to its full complement.

Complaints/Requests for Advice/Enquiries

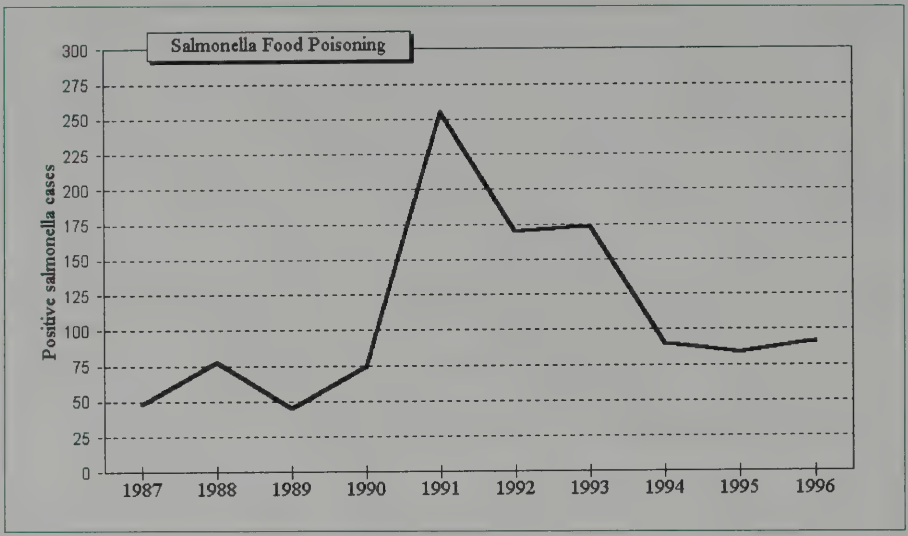
A total of 5996 complaints/requests for advice/enquiries were received during the year: This figure represents a reduction of approximately 11% compared with the previous year. The details are shown in the tables and the graph.

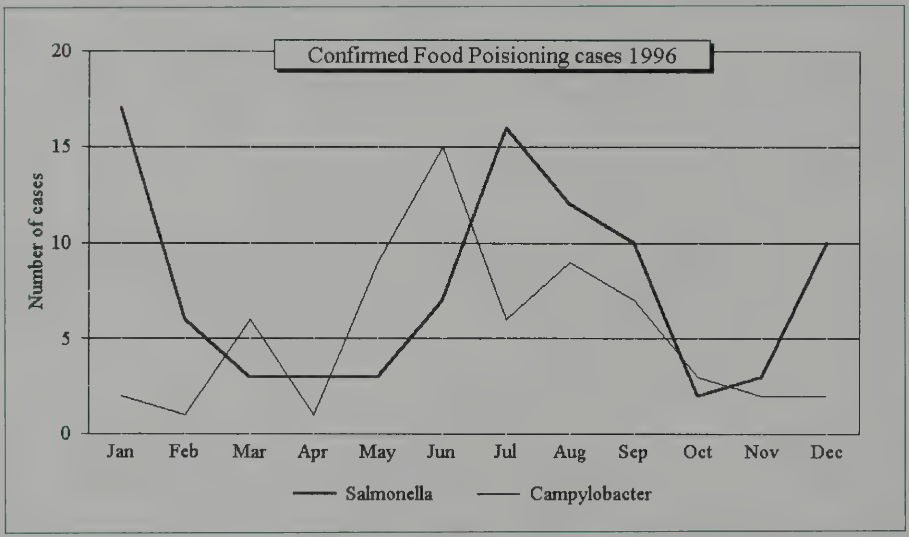
Food Safety and Infection Control

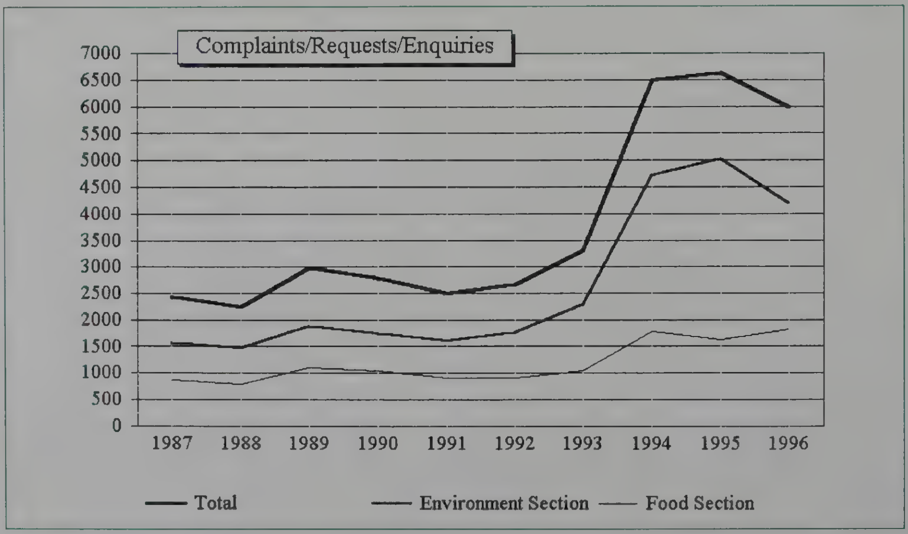
Whilst there was a reduction in the overall number of complaints, etc., the Food Safety section dealt with a total of 1811 complaints, etc. - an increase of 12% over the previous year. In the main this increase can be attributed to advice sought regarding the introduction of new food legislation.

Food Safety and Infection Control

Food Condition	135
Food Poisoning	342
Food Safety	746
Food Surrender & Advice	58
Miscellaneous	530
Total	1811


Salmonella Food Poisoning
Positive salmonella cases
300
275
250
225
200
175
150
125
100
75
50
25
0
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996


Confirmed Food Poisioning cases 1996
Number of cases
20
15
10
5
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Salmonella
Campylobacter


Complaints/Requests/Enquiries
7000
6500
6000
5500
5000
4500
4000
3500
3000
2500
2000
1500
1000
500
0
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
Total
Environment Section
Food Section

Food Complaints

53 complaints were made to the department during the year. Of these, 23 were either unsubstantiated or the source of the problem occurred (accidentally) in the complainant's home. The remainder related to food not being the nature, substance or quality demanded by the purchaser. None were of such seriousness as to warrant formal action.

Food Surrender

A total of 22 certificates were issued during the year: an indication that the Board's policy of charging for the issue of certificates continues to have the desired effect of releasing officer time.

Education

The Environmental Health Officers continued to promote the Chartered Institute of Environmental Health's Basic Food Hygiene Certificate course. A total of 56 candidates attended a total of 8 courses run by the department

Food Poisoning

The Department received notification of 92 confirmed cases of Salmonella food poisoning (16 of these were known to have been contracted outside the Bailiwick) together with a further 63 confirmed cases of Campylobacter. There was 1 case of E. coli 0157: contracted outside the Bailiwick. Once again there was an outbreak involving Baked Alaska served as part of a celebratory meal at a local restaurant - 10 persons out of a party of 16 were affected by Salmonella. There was a further small outbreak at another restaurant, affecting 3 persons out of a party of 8, involving chocolate mousse.

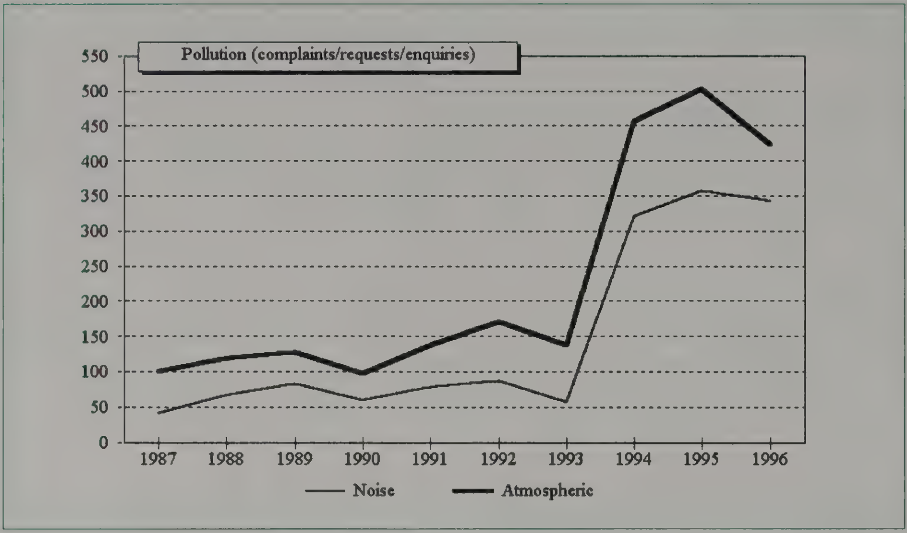
It has to be stressed, yet again, that dishes made with uncooked fresh eggs pose the risk of salmonella food poisoning and previous advice given to all hotels and restaurants is repeated: *"to avoid similar problems, use pasteurised liquid egg for catering purposes"*.

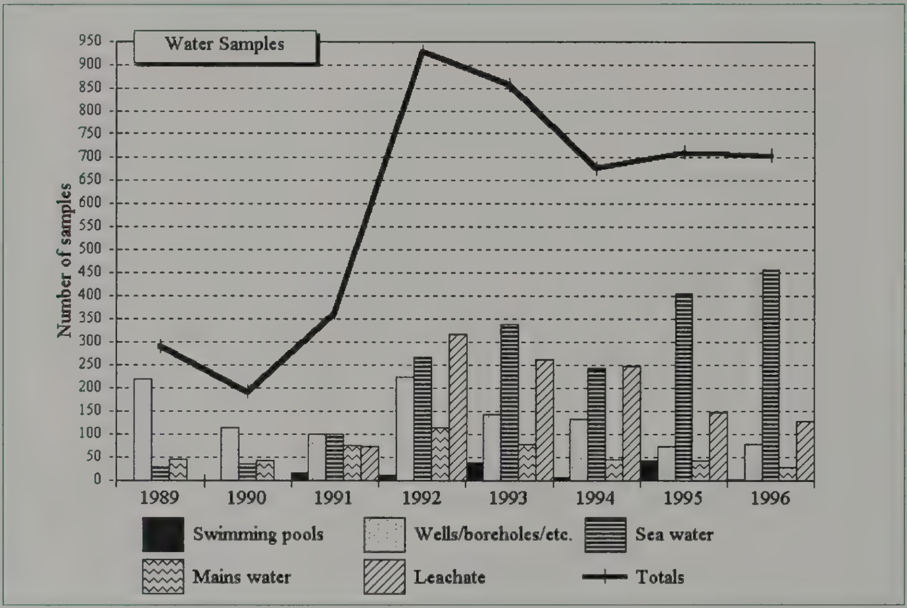
Control of the Physical Environment

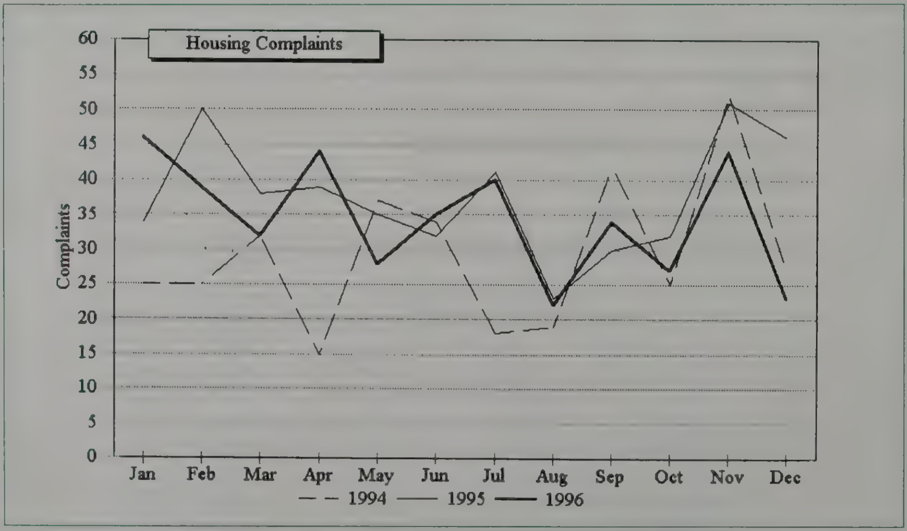
A total of 4185 complaints/requests/enquiries were dealt with during the year. This represents a reduction of approximately 20% over the previous year. Details are shown in the table below.

Environmental Control

Housing	414
Pollution - Atmospheric	423
Pollution - Land/Water	379
Pollution - Noise	343
Rats/Mice/Pests	1271
Water sampling	364
Miscellaneous	991
Total	4185


Pollution (complaints/requests/enquiries)
550
500
450
400
350
300
250
200
150
100
50
0
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
Noise
Atmospheric


Water Samples
Number of samples
950
900
850
800
750
700
650
600
550
500
450
400
350
300
250
200
150
100
50
0
1989
1990
1991
1992
1993
1994
1995
1996
Swimming pools
Wells/boreholes/etc.
Sea water
Mains water
Leachate
Totals


Housing Complaints
Complaints
60
55
50
45
40
35
30
25
20
15
10
5
0
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
1994
1995
1996

Water Samples

The following samples were taken during the year for bacteriological and/or chemical sampling.

Water Samples

Swimming pools	2
Wells/Boreholes	78
Sea Water	456
Mains Water	28
Leachate	127
Other Water Sources	11
Totals	702

Rodent and Pest Control

A total of 659 complaints or requests for assistance were dealt with by Rodent Control staff and a total of 1336 treatments were carried out. Staff also carried out 131 disinfestations.

The Department continued with its programme of the systematic treatment of bays and headlands and staff carried out 835 treatments during the year.

Housing

414 complaints of unsatisfactory conditions were received during the year. Complaints were mainly concerned with unsatisfactory living conditions, overcrowding dampness and defective drainage. The accompanying graph shows the frequency of complaints.

Air Quality Monitoring

The Department continued to monitor nitrogen dioxide and sulphur dioxide levels. Nine sites measuring nitrogen dioxide were in operation for the whole of 1996 whilst one site monitoring sulphur dioxide operated near the Vale Power Station.

Measured levels of sulphur dioxide remained very low, indicating "Very Good" air quality, based on the United Kingdom Department of the Environment's Air Quality Banding. The levels are now at or below the detection limits of the measuring equipment.

Nitrogen dioxide levels were similar to 1995. Fountain Street again reached the highest levels with a monthly average of 19.51 ppb (parts per billion) with peaks of 25.53 ppb (in June) and 26.00 ppb (in September). This compares to an average of 20.28 ppb in 1995 and a peak August level of 26.18 ppb. Rural average levels were below 10 ppb. "Very Good" air quality is indicated by levels below 50 ppb: based on the Air Quality Bandings.

The Environmental Health Department commissioned a report on the siting of real time air quality monitoring equipment to measure nitrogen dioxide, sulphur dioxide, carbon monoxide, particulates and ozone. This would involve setting up a roadside, an urban background and a rural site to monitor these pollutants. A survey of the Island was carried out in the latter part of the year by The South East Institute of Public Health and their report and recommendations were awaited at the year end.

Nitrogen Dioxide Survey Results (Yearly Avergaes)

Site	1992	1993	1994	1995	1996
College Street	17.42	15.36	14.03	14.91	17.85
Princess Elizabeth Hospital	5.74	9.86	6.83	7.69	8.23
Nr Corbiere	3.32	5.52	3.62	3.86	5.19
South Side	8.79	14.80	12.15	13.58	14.78
La Passee	6.57	7.16	6.37	6.33	6.91
Fountain Street				20.28	19.51
Commercial Arcade				9.47	10.11
Albert Statue				14.16	15.58
Trinity Square				13.82	15.25

Results in parts per billion

▨ Indicates results incomplete for the year

M Bairds
Chief Environmental Health Officer

Chapter 4

Health Promotion

Introduction

The work of the Unit has continued to be varied with an emphasis on the priority areas of preventing cancer and heart disease and promoting all aspects of a healthy lifestyle.

The major event of 1996 was the move in July of the Unit into new premises. Now situated under Sherwill Ward, next door to Bulstrode House at the Princess Elizabeth Hospital, the extra space has meant that trainings for larger numbers can be carried out in situ and the storage space for resources has increased so that the library is more accessible. All resources have been entered on to a new computerised system, making the booking and loan service much easier and more efficient and enabling more accurate statistics to be kept. During the first year of operation over 22,000 leaflets were given out and more than 200 different clients borrowed over 850 resources.

Progress in other areas was as follows:-

Smoking

Much of the Assistant Health Promotion Officer's time in 1996 and the beginning of 1997 was spent on smoking. This included detailed research for the Board's proposed tobacco legislation and liaison with the Parents Against Tobacco Group and Smokebusters Charity. A seminar on the benefits of increasing tobacco taxation by two UK speakers was organised in the lead up to the States Debate and then, following the decision to increase the taxation, work has been going on to use the funds to help stop children from starting smoking and helping smokers who want to stop.

This has included the organisation of the distribution of free supplies of nicotine replacement patches and, during 1997, will include a grant to the Smokebusters charity to enable them to employ a full time co-ordinator and the employment of a part-time smoking cessation counsellor.

Plans are already underway to bring over a UK G.P. to run seminars on smoking cessation for professionals and a worker from the UK charity Quit to run a smoking awareness programme in secondary schools.

No Smoking Day saw the launch of the joint Channel Island smoking initiative in Jersey and Guernsey so that both Health Promotion Units now have materials which include the new logo. The Channel Island Smoke-Free Guide to Eating and Drinking was launched in the Autumn and this includes over 70 local establishments.

Other smoking activities included a smoking cessation course for prison inmates and smoking cessation training for student nurses, conversion course nurses, practice nurses and midwives.

A survey of cigarette vending machines is planned for 1997.

Coronary Heart Disease

The Look After Yourself programme continued to flourish with a variety of courses run for the general public, cardiac rehabilitation patients and for those wishing to lose weight. The weight management courses have proved to be very popular and there are plans to expand this area in 1997. It is also planned to train several new tutors through a training course to be held in Jersey in the late autumn.

A number of sessions on healthy lifestyles and healthy eating for workplaces and health professionals were run by the Health Promotion Officers, including banks and the Fire Brigade, and regular sessions were included in the Civil Service staff induction programme. The Assistant Health Promotion Officer also completed the draft information leaflet for patients travelling to Jersey or the UK for medical treatment and it is hoped this will be published next year.

Cancer

The Assistant Health Promotion Officer continued the series of successful cancer awareness workshops for workplaces and also for professionals including sessions for the Family Centre and nursing auxiliaries.

Work was centred around the prevention of skin cancer during the summer months and publicity given to the need to protect skin from burning. A workshop was held for professionals which attracted nearly 60 participants. This area will be further developed in 1997, particularly concentrating on children.

Alcohol and Drugs

The Health Promotion Officer continued to attend meetings of Drug Concern and the Dependency Sub Committee. Several training sessions were held for secondary school teachers and publicity was given to the new sensible drinking daily benchmarks. A publicity campaign linking in with the publication of the local report on alcohol is planned for 1997.

Sexual Health

The work on HIV/AIDS was concentrated around World AIDS Day with two successful training sessions held for the general public and several held for nurses and charity groups.

The Health Promotion Officer also contributed to training sessions for teachers on sex education put on by the Complementary Health Educators. Regular contact was maintained with the CHEs and also with the new manager of the Family Planning Clinic and this is planned to continue with the development of the Family Planning Services in 1997.

Family Health

The Unit continued to support the work of the Health Visitors and School Nurses in their health educator roles. Publicity events were organised for Breastfeeding Awareness Week and the Health Promotion Officer attended meetings leading to the application for Baby Friendly Hospital status.

Accident Prevention

The Child Accident Prevention Group held a very successful pilot event for 120 Year 6 school children at Oakvale School. The "Safety Calling Challenge" included most organisations in the group and involved children taking part in eight different scenarios on the prevention of accidents or dealing with an accident including making a 'real' 999 call. Positive feedback from the organisations and schools taking part has meant that a second larger event for over 350 children is planned for June 1997.

Other events included monitoring the newly computerised accident statistics gathered at the P.E.H. and linking with the newly formed Jersey Child Accident Prevention Group.

Mental Health

The Health Promotion Officer supported a working group from the Mental Health -Services in mounting a successful campaign for World Mental Health Day, including a series of different media articles.

A variety of sessions on stress management was run for groups including workplaces and the Police Force.

The Health Promotion Officer joined an Education Department Working Group on stress management and helped to survey all island teaching staff on the causes of stress and stress levels. The Group is now examining the results of the survey and a draft stress policy is planned for 1997.

Health Education for Schools and Young People

The Health Promotion Officer led a training day for a junior school on writing their Personal, Social and Health Education Policy and co-tutored a weekend training on peer-led education for youth workers. Support was given to several schools over the PSHE curriculum as well as workshops on self esteem and group work skills.

Training

Training programmes attended by Health Promotion Unit staff included computer and spreadsheet skills, media awareness, weight management and NVQ Assessor courses. The Resources Officer also attended the annual Resources and Information Conference in Milton Keynes.

Liaison

Regular meetings and contact were maintained with the Jersey Health Promotion Unit staff and resources officer including an inter-island exchange of trainings for Look After Yourself tutors. It is envisaged these links will be further strengthened with the planned joint Jersey Guernsey tutor training course in the autumn of 1997.

Conclusion

1997 promises to be another busy year with the fruition of the plans for the tobacco taxation funds and campaigns on the promotion of exercise and sensible drinking as well as a larger Child Safety Week event and the new LAY tutor training course.

Yvonne Le Page
Health Promotion Officer

Chapter 5

Communicable Disease Control

Communicable Diseases

- **"Food Poisoning"**

  Episodes of food poisoning causing diarrhoea and vomiting have continued to be the most common notifiable disease in terms of frequency, if not of seriousness amongst the general population. For the very young and very old however, food poisoning can be very much more critical, and it is therefore important to do everything possible to reduce the likelihood of new cases, or to prevent their onward spread should they occur. Apart from personal illness, inconvenience and time lost from work, any occurrence of food poisoning originating in a catering establishment also harms Guernsey's reputation as a tourist destination.

  In order to reduce the likelihood of occurrence, it is essential that the whole food preparation chain maintains the highest standard of food hygiene. Good quality food stuffs should be selected and should be fresh and properly stored. They must be transported at sufficiently low temperatures to prevent the multiplication of bacteria and prepared in a clean environment, where no cross-contamination with other foodstuffs can take place. Food handlers must be in good health and observe proper food hygiene precautions. All food stuffs of animal origin must be adequately cooked, and food must be freshly and hygienically served without chance of contamination from uncooked food.

- **Meningococcal Disease**

  Three cases of Meningococcal disease also occurred. One of these was meningitis and two caused septicaemia. One occurred in a child who was on holiday in the UK, whilst another was clinically notified but was not confirmed on subsequent bacterial testing. All cases were sporadic and not related to any other known case. Although a lot is heard regarding outbreaks or clusters of meningococcal meningitis, it is sporadic cases occurring in the community which are far more common. The meningococcus bacteria is a normal commensal or contaminant of the throat in a significant proportion of the population, and the reasons why it may lead to active infection are poorly understood.

- **Tuberculosis**

  Several cases of tuberculosis were also identified. One of these was diagnosed in India and treatment started there, although this diagnosis could not be confirmed when the patient returned to Guernsey. Another case occurred in a spouse of someone already being treated for tuberculosis, again demonstrating the importance of contact tracing. A third case was a re-activation of recently treated disease.

Report to the Department of Health
Notification of Infectious Diseases 1996

						1996 (Quarters)				
	1991	*1992*	*1993*	*1994*	*1995*	*1st*	*2nd*	*3rd*	*4th*	Total
Measles	2	0	2	1	1	**0**	**0**	**1**	**0**	**1**
***Mumps**	0	0	1	0	0	**0**	**0**	**0**	**0**	**0**
***Rubella**	3	0	4	0	4	**1**	**3**	**1**	**1**	**6**
Whooping Cough	3	2	0	4	6	**0**	**0**	**0**	**0**	**0**
Food Poisoning	47	38	61	13	10	**7**	**0**	**7**	**4**	**18**
Hepatitis A	1	0	0	0	1	**0**	**0**	**0**	**0**	**0**
Hepatitis B	2	1	2	0	2	**0**	**0**	**0**	**0**	**0**
Meningitis	3	1	2	1	4	**1**	**2**	**0**	**1**	**4**
Tuberculosis	6	1	2	4	6	**1**	**0**	**3**	**1**	**5**
Malaria	0	1	0	0	0	**0**	**0**	**0**	**0**	**0**
AIDS - notified annually	0	0	0	0	0					
Scarlet Fever	3	2	1	1	1	**0**	**1**	**0**	**0**	**1**
Psittacosis	0	0	0	0	5	**0**	**0**	**0**	**0**	**0**
Dysentery	0	0	2	0	0	**0**	**0**	**0**	**0**	**0**
Other infectious conditions that were reported informally										
Hepatitis C					1	**0**	**0**	**0**	**0**	**0**
Food Poisoning	212	130	187	127	128	**30**	**37**	**54**	**21**	**142**
Carriers of HIV Antibody - notified annually	**0**	**0**	**1**	**5**	**1**					

* Mumps and Rubella became notificable in Guernsey on 1.1.89

There were also two further cases which further investigation showed to be due to a related organism and were not tuberculosis. The tubercle bacillus is not easy to culture, and consequently decisions usually have to be made on clinical grounds in order that tracing and assessment of contacts is not delayed. Frequently however the initial clinical diagnosis can not be confirmed subsequently. Fortunately the number of cases of tuberculosis in Guernsey remains very low, and this supports present policy of only offering selective BCG immunisation.

- **Rubella**

Three case of Rubella (German measles) occurred in adult males. This reflects the fact that until recently, boys were not offered Rubella vaccination at school. As infection with Rubella has become less common in the community, fewer males have become infected in childhood, and are consequently still susceptible to the illness when reaching adulthood. This should change over the next few years, because the current recommended immunisation programme offers MMR (Measles Mumps Rubella) vaccine to both boys and girls at thirteen months of age, together with a second dose prior to starting school. As the pool of susceptible individuals in the community declines, so Rubella and the risks of congenital Rubella born to affected mothers should become increasingly rare.

- **Further Reducing Communicable Disease**

The two essentials to further reduce the already low levels of communicable diseases in Guernsey depend firstly on doing everything possible to ensure that the whole population, but particularly young children, are fully immunised against the recommended vaccine preventable diseases. The second essential is to ensure that the very highest standards of food hygiene are maintained when storing, transporting, handling, cooking and serving food.

Dr. Brian Parkin
Deputy Medical Officer of Health

Infection Control Committee

The Infection Control Committee continues to be responsible for Infection Control on all Board of health premises, and to act in an advisory capacity in infection control to other States committees, and health workers in the private sector.

The Committee is required to;

- review the annual infection control programme
- review recent outbreaks
- review all procedures in relation to infection control
- discuss specific areas of concern from the infection control team
- agree guidelines for the surveillance of infections and infection potential
- review and anonymise results in infection control audits

SEXUALLY TRANSMITTED DISEASES

ANNUAL STATISTICS 1996

DISEASE	MALE	FEMALE	HOMOSEXUAL	TOTAL 1996	TOTAL 1995
Gonorrhoea	5	0	0	**5**	6
Syphilis	1*	2	1*	**3**	2
N.S.U./Chlamydia	26	18	0	**44**	40
Herpes Genitalis	23	21	1	**44**	27
Yeast	30	41	0	**71**	77
Hepatitis B	0	0	0	**0**	0
Hepatitis C	1	1	0	**2**	3
Human Papilloma Virus	42	40	0	**82**	80
Pubic Lice/Scabies	8	5	0	**13**	22
Gardenerella Vaginalis	0	18		**18**	23
Trichomonas Vaginalis	0	0	0	**0**	–
Cervical Smears		27		**27**	25
Counselling	77	69	3	**149**	107
HIV Blood Testing	51	47	2	**100**	66
STD Screening	81	79	0	**160**	–
TOTALS					
New Patients	107	80		**187**	160
Attendances	312	256		**568**	446

Strategic objectives for the Infection Control Committee during 1996 included;

- Computerisation of the laboratory service
- Improved and appropriate antibiotic prescribing
- improved management of infected and contaminated waste
- Infection Control Link Nurse course
- achieving Kings Fund Audit Accreditation
- targeting infection control origin amongst staff

At review, substantial progress had been made to achieving the above objectives, in particular, the infection control service met all "A" rated criteria of the Kings Fund Organisational Audit. Further strategic objectives have been set for 1997/8.

Genito-Urinary Medicine

Sexual Health Clinic (previously Special Treatment Clinic)

The Clinic took on a new name and identity this year which represents a change of emphasis from the treatment of disease towards the promotion of sexual health and wellbeing. There has been a further demand on the services of Genito Urinary Medicine, both in the provision of the Sexual Health Clinic, and in the supervision of HIV care.

Increasingly, sexually active people of both sexes are seeking advice and check ups with regard to their sexual health. This is reassuring, but as a consequence of the success of the clinics, the accommodation, allocation of staff time and resources is inadequate to meet the demands of a modern and expanding service.

Historically the management of sexually acquired infections has been seen as a low priority, and funded as a "Cinderella" service. This will have to change if there are to be real reductions in sexually acquired infections and their attendant morbidity. Discussion is underway with officers of the Board of Health with regard to re-housing the Clinic and an expansion of this Service.

The relatively high rate of gonorrhoea for the second year running is a direct result of infection from abroad. These cases have embarked on "sexual tourism" where the individual has gone on holiday to the Far East, specifically looking for a sexual encounter.

These encounters are extremely "high risk", as many of the countries visited have a high background incidence of HIV as well as gonorrhoea and other sexually transmitted infections amongst their sex workers. It is important for people to be aware of the risks they subject themselves to when they have unprotected intercourse in such settings.

Three cases of syphilis were detected. The single male patient had presented with AIDS, and syphilis was found on the subsequent screening. The female patients were detected at routine antenatal screening and were presumably infected many years ago. This highlights the need to continue antenatal screening for syphilis in pregnant women. The emergence of an epidemic of syphilis in Russia, with subsequent spread to Europe and the UK highlights the need for continued vigilance.

The Clinic staff as well as giving information with regards to sexually acquired infections, also discuss the need for contraception and safer sex practices. The prescription of the post coital pill has been required as emergency contraception for several patients seen in the Clinic.

HIV/AIDS

During 1996, ten patients who were HIV positive were known to the Clinic. This included three new previously undiagnosed cases of HIV. A further HIV positive was referred to the Clinic from mainland Europe when he moved to Guernsey. From a treatment and education perspective, it was distressing to see that two of these new diagnoses had occurred in patients who presented with acute AIDS. Both these patients had known risk factors, but had never presented before for testing.

1996 proved a milestone in the quest for effective treatment of HIV, which is grounds for some optimism. Trial data presented at the International Conference on AIDS in Vancouver showed that the beneficial effects of using combination anti retro-viral treatment when compared with monotherapy. Product licences for new classes of anti retro-viral drugs were granted in the UK, which then became available for local prescription. Further advances were made in the understanding of the pathogenesis and progression of HIV infection and the ability to monitor the disease through the use of surrogate markers. The measurement of the amount of virus in the blood or “viral load” is one such surrogate marker.

Six patients during 1996 received some form of combination treatment, mostly in the form of a dual combination regime. At the latter half of 1996, triple combination drug regimes were introduced for four patients, based on changes in their individual “viral loads”. There was one death; a male patient who presented late with advanced AIDS but who failed to respond to any form of anti retro-viral therapy.

At the end of 1996 all the patients on combination anti retro-viral treatment had shown a sustained benefit, and the hope is that continued viral suppression can be maintained with these drug regimes, without subsequent drug toxicity or the emergence of resistance.

Dr Nick King
Sexual Health Clinic

Chapter 6

Occupational Health and Safety

Occupational Health Services

January 1996 saw the start of a very busy and successful year in the further development of Occupational Health Services both for the Board of Health employees, and more generally for other States employees. A number of initiatives first implemented during the year have now begun to produce results. Departmental objectives have been set, and progress towards achieving these has been substantial.

Kings Fund Organisational Audit

The new Department's initial priority was to ensure compliance with all the "A" criteria required by the Kings Fund Organisational Audit. The service received a commendation by the auditors for the development of a comprehensive range of policies and procedures for health screening and surveillance, as well as guidelines for employees who have work related illness or injury.

Occupational Health Computer Package

Accurate and confidential record keeping is an essential component of effective Occupational Health. There are several specially written software programmes available - Occupational Practitioners Administration System (OPAS) from Warwick IC Systems, was eventually chosen as it came closest to meeting all pre-set requirements. The system was installed in December 1996, and Warwick IC Systems have shown a high level of customer service both during installation, and through maintaining a very useful help line. It is now intended to use the system to audit the various activities undertaken by the Department, in addition to allowing more accurate documentation, call and recall for immunisation necessary to protect staff against vaccine preventable diseases such as Hepatitis B.

Monitoring Sickness Absence

A key function of Occupational Health is to examine trends and patterns of absence due to sickness, work related ill health and accidents, with a view to minimising these. A Sickness Absence Working Party has been established, and are currently examining available data - initially from selected departments at the Princess Elizabeth Hospital. This is seen as a pilot project, and demonstrated success in reducing avoidable sickness absence through joint working between line managers, the Chief Nursing Advisor, the Personnel Department and Occupational Health will encourage adaptation of this approach to other Board of Health sites.

Utilisation of the Occupational Health Service

Regular clinics have been held on two sites during 1996/7.

- **Lukis House**

The established Occupational Health Clinic has continued to be run at Lukis House during the year. During this time, the Clinical Medical Officer saw 112 people, whilst a further 385 were seen by the Occupational Health Nurse for immunisation. Breakdown was as follows:

	Board of Health Employees	Employees - Other States Departments
Pre-employment medicals	10	35
Special Medical Examinations		
- Sickness Absence	10	9
- Ill Health Retirement	1	7
- Lung Function Tests	6	40
Immunisations		
- Hepatitis B	204	133
- Rabies	0	33
- Polio	1	
- Influenza	14	

- **Princess Elizabeth Hospital Site**

A wide range of activities have been undertaken at the Princess Elizabeth Hospital, including screening of 263 health questionnaires, of which 35 required pre-employment medicals, referrals from line managers for health assessments due to sickness absence on a further 20 employees, and advice given on work related illness on a further 74 employees.

Throughout 1996, regular departmental meetings have been held between the Director of Public Health, Clinical Medical Officer and the Occupational Health Nurse to co-ordinate the further development of the Service.

- **New Occupational Health Suite**

One of the main accomplishments during the year has been to ensure the successful relocation of the Occupational Health Service to a special Occupational Health Suite at the Princess Elizabeth Hospital. This will enable the centralisation of all Occupational Health functions, and a move away from Lukis House.

The Service will operate from a newly refurbished office suite, with the official opening due to take place in late Summer 1997. A promotional leaflet summarising the range of services offered is planned for distribution to all employees of the Board of Health to coincide with this, and will also be given to all new employees as part of their induction process.

Advice and Consultancy

A wide range of people have been helped by the Service in their request for advice by telephone, through visits in person, through educational sessions requested by them e.g. Hepatitis B for student nurses at the Nurse Education Centre, "Introduction to HIV" on the Infection Control Link Nurse Course.

Committee meetings attended by the Occupational Health Nurse included

- Health & Safety Working Group
- HIV/ AIDS Sub-committee
- Infection Control Committee
- Manual Handling Group (PEH)
- Health Promotion Links Agency

The Occupational Health Nurse continues to provide regular input into the multi-disciplinary and nurses induction days.

Conclusion

The work of the Service during 1996/7 has developed a sound infrastructure on which further development can be built.

It was successful in achieving its aims for 1996, and objectives for 1997 have now been set as follows

- To computerise vaccination records and recall system
- To implement immunisation programmes in the workplace
- To further develop "healthy workplace" initiatives through joint working with the Health Promotion Unit
- To visit Alderney and advise on Occupational Health requirements in that island.
- To further develop the "Reducing Sickness Absence" initiative

Another busy year is assured.

Mrs Pamela Smith
Occupational Health Nurse

Fire Health and Safety

A full time Health and Safety Adviser was appointed for the first time in September 1996. The position is an external one, and functions on a "consultancy" basis. Although based at the Princess Elizabeth Hospital, it is intended that the support and advisory function extends to all Board of Health sites.

The role of the Fire Health and Safety Adviser is co-ordinated through the Health and Safety Working Group, of which the Fire Health and Safety Adviser is Secretary.

Policies and Procedures

Health and Safety issues form an important component of the Kings Fund Organisational Audit, and an initial challenge for the Fire Health and Safety Adviser was to collect and collate existing policies and procedures relating to Health and Safety from the various departments at the PEH. Deficiencies were identified, and a number of new policies developed. There is obviously further work to be done in this area.

Fire Safety and Education

Good links continue to be developed with the Guernsey Fire Brigade. Full scale evacuation exercises testing the response of staff and Brigade in a fire and smoke logged situation were carried out in December. De Saumarez Ward was utilised during its Christmas Closure and mock patients filled its beds instead. Staff from all departments of the Hospital were called in to man the ward. The Brigade's Fire Safety Department smoke-filled the ward leaving staff to cope with a full evacuation down the stairs into Bio-Chemistry.

On arrival, the operational Fire Crews needed to locate the seat of the fire (the smoke machine) and extinguish it. The exercise, the first of several planned, showed a few problems for both the Brigade and staff, and resulted in policy and procedure changes along with Fire Lectures being restructured to meet the needs of the hospital more closely.

The "Fire I" lectures covering how to sound an alarm, what to do when the alarm sounds and the concept of horizontal evacuation are now all taught "in house". This leaves the Fire Brigade to deal with the established "Fire II" lectures, which involve "hands on" fire extinguishing practice, and the newly introduced "Fire III" sessions for portering, catering and maintenance staff covering the extinguishing of larger fires. This utilises the Airport Fire Brigade training rig allowing everyone to experience the extinguishing of consistently large fires.

Alderney held a day of lectures for all its staff. The Fire, Health and Safety Advisor and the Guernsey Fire Brigade Fire Safety Department travelled to the Mignot Memorial Hospital to carry out both Fire I and Fire II lectures for all staff. Although there is no legal obligation, Alderney also completed a Health & Safety Audit and full Fire Brigade Inspection with few problems presenting themselves.

Over 100 staff per month attend Fire training sessions and Fire Drills are now being held regularly across BoH sites. Brigade inspections of premises showed fewer problems than in the past reflecting the excellent work carried out by the Board of Health Works Department.

Accident and Incident Reporting

The new accident and incident forms are to be introduced in 1997. This will enable trends to be accurately detected and problems rectified more rapidly through identifying these patterns. The forms also encourage the reporting of near misses, perhaps one of the most important tools of accident prevention. By analysing "near misses" it will enable us to accurately predict areas of concern and resolve risks before an accident happens.

Manual Handling Training

Moving and handling has been addressed right across the board and deserves the commitment that has been put in both training and equipment. As back injuries are the largest single preventable cause of sickness and nursing is recognised as the largest at risk group this is an area that constantly needs to be developed. Other groups involved in moving and handling should not be forgotten and training and equipment provided where the need has been assessed.

Substances Hazardous to Health

Use of substances hazardous to health has always been carefully controlled as a consequence of the environment in which the work is carried out. The introduction of systems to record these controls and the assessments that lead to the controls will enhance the programme already in place.

The Health & Safety Executive are always very helpful and willing to assist wherever asked. The misapprehension that the Executive is a prescriptive body has frequently been proved wrong, as their aim is often the same as ours - although their approach is different.

The Risk Management Approach

The Board of Health has realised that Risk Management and more general health safety concerns are closely linked, and that policy review needs to reflect this philosophy, including risks that are not necessarily Health & Safety. These include clinical risk, computer risk, business interruption and financial risks amongst many others.

The Acute Hospital Services, Mental Health and Elderly Care and Community directorates are all incorporating Risk Management strategies as part of their Health and Safety Policies. Management and staff are receiving appropriate training accredited by the institution of Occupational Safety and Health.

The key to all health and safety issues is Risk Assessment and Risk Management. The Board of Health, by following this path, can become one of the leaders in the management of Health & Safety in Guernsey.

Mark Guilbert
Fire Health & Safety Adviser

Health & Safety Working Group

The Health & Safety Working Group has been given the responsibility to implement the Board's Health & Safety Policy which was adopted to replace a previous Policy in March 1994. The Working Group was given the following Terms of Reference;

- To ensure that the contents of the overall Health & Safety Policy were promulgated and implemented.
- To ensure the establishment, monitoring and regular review of all sectional and departmental health and safety policies.
- To provide line managers and the Executive Team with a contact point for advice and guidance for all Health & Safety matters covered under the Policy, including training.
- To monitor and review statutory provisions concerning Health and Safety to determine the impact on Board of Health services.
- To co-ordinate and prepare an Annual Report to the Board of Health on Health and Safety issues and practices on Board of Health premises.

A strategic plan with nine objectives for 1996 was adopted, with the target of more than two-thirds completion during the course of the year being sought. In the event all but one of the objectives (that relating to COSHH) have been fully or partially achieved.

Further objectives are being developed for implementation during the forthcoming year.

A further development has been twice-yearly meetings with Health and Safety Representatives from all Boards of Health Sites, providing a useful communications point to discuss both specific and more general Health and Safety concerns.

The Working Group will continue to meet every second month, with progress towards selected further objectives being minuted during the coming year.

Chapter 7

Guernsey and Alderney - Vital Statistics

- Births and Birth Related Data
- Deaths and Death Related Data
- Guernsey deaths by ICD-10 Codes and Age Groups 1996
- Alderney Vital Statistics

7.0 Guernsey - Vital Statistics 1996

● Births and Birth Related Data

	Guernsey		
	1996	5 Year Mean 1989-1993	England & Wales 1996*
Estimated Mid Year Resident Population:	56,681	58,867	51,820,200
• Males	28,244	28,297	25,453,100
• Females	30,437	30,570	26,387,100
• M : F	0-928	0-925	0-964
Population Density [Area 63.1Km^2]:	930	933	236 (UK)
Marriages:	340	401	291,000
• Marriages/000	5.79	6.81	5.6
Divorces:	199	173	155,500
• Divorces/000	3.4	2.93	3.0
Divorces : Marriages	0.58	0.43	0.53
Births:	660	725.6	653,024
• Males	335	370.8	335,298
• Females	325	354.8	317,726
• M : F	1.03	1.045	1.055
Births outside marriage:	177	148.2	234,088
• % All Births	26.8%	20.4%	35.8%
Stillbirths:	3	4	3,539
• Rate/100 Live Births	4.54	5.5	5.4
Infant Deaths:	5	4.2	3,989
• Infant Death Rate	7.57	5.7	6.1
Crude Birth Rate:	11.2	12.3	12.5
Natural Fertility Rate:	51.3	53.3	60.5
Natural Increase per annum:	+0.08%	0.20%	0.16%

***Figures for England and Wales are for 1996, or if not, from the most recent published data.**

Guernsey Births and Birth Related Data

Resident Population and Population Density

The total resident population is based on the 1996 Census data which was performed in April of that year. Total population numbersw recorded at the Census were slightly lower than previously estimated population numbers.

Marriage and Divorce

Total numbers of marriage in Guernsey continue to decline, whilst divorces have shown a 30% increase over the year. For the first time in post-war years, the rate of divorce per 1,000 population in Guernsey appears to exceed that shown in England.

Births and Births Outside Marriage

Although total births for 1996 show a slight increase above 1995 levels, they are still below the five year mean for 1989-1983. Both Crude Birth Rate (births per 1,000 total population) and Natural Fertility Rate (births per women of child bearing age defined as 15-45 years) remain significantly below the equivalent for England and Wales.

Although there are fewer total births, a lower proportion are born outside marriage than in England and Wales, where this proportion continues to rise.

Stillbirths, Infant Deaths

The small numbers in both these categories make interpretation on an annual basis difficult. There have been fewer stillbirths, but more infant deaths than in 1995.

Natural Increases

The natural increase is the difference between the crude birth and crude death rates, expressed as a percentage of the resident population. There remains a slight excess of births over deaths, making the natural increase just over replacement value.

7.0 Guernsey - Vital Statistics 1996

• Deaths and Death Related Data

	Guernsey		
	1996	5 Year Mean 1989-1993	England & Wales 1996
Total Deaths:	611	591	563,007
• Males	272	294	269,828
• Females	339	297	293,182
• M : F	0.80	0.99	0.92
Crude Death Rate:	10.4	10.0	10.9
Circulatory Deaths (I00-I99):			
• Males	382	417	424
- Rate/00,000			
• Females	467	402	424
- Rate/00,000			
Cancer Deaths (C00-C97/D00-D48):			
• Males	265	332	282
- Rate/00,000			
• Females	279	255	251
- Rate/00,000			
Lung Cancer Deaths (C34):			
• Males	56.6	101.7	80.2
- Rate/00,000			
• Females	36.1	45.1	42.0
- Rate/00,000			
Breast Cancer Deaths (C50):			
• Females	55.8	41.14	47.4
- Rate/00,000			
Alcoholic Liver Disease (K70):			
• Males	9.54	12.7	8.5
- Rate/00,000			
• Females	9.9	8.4	5.5
- Rate/00,000			
Injury Deaths (S00-X59):			
• Males	31.8	14.1	27.7
- Rate/00,000			
• Females	9.85	9.2	17.6
- Rate/00,000			
Suicide Deaths (X60-X84):			
• Males	21.2	9.9	11.0
- Rate/00,000			
• Females	6.6	4.6	3.0
- Rate/00,000			

Guernsey Deaths and Death Related Data

Total Deaths and Crude Death Rate

There were rather more female deaths than normally recorded during 1996, leading to a lower ratio of male-to-female deaths. The crude death rate at 10.4/1,000 remains the same as for 1995, and well below that for England and Wales.

Circulatory Deaths

Deaths from ischaemic heart disease, cerebrovascular disease, and hypertension remain the commonest cause of death, amongst both males and females in Guernsey. Although generally below rates for England and Wales, there were an unusually high number of female deaths certified as being due to circulatory disease during 1996.

Cancer Deaths

Cancers (all causes) remain the second leading cause of death amongst both men and women in Guernsey, although unusually than the equivalent rates for males in England and Wales.

Female deaths from breast cancer were slightly higher than usual, but with a lower than usual rate during 1995 it is likely that the five year mean will remain largely unchanged.

Alcoholic Liver Disease

This was lower than normally recorded amongst Guernsey males, but higher amongst Guernsey females. Again small numbers make interpretation of trends difficult.

Injury and Suicide Deaths

Deaths from injury amongst Guernsey males are somewhat higher than usually recorded, and amongst Guernsey females somewhat lower.

Deaths from suicide deaths are higher for both males and females than the five year mean. This trend will continue to be monitored.

7.3

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total		Under 1		Age 1 - 14		Age 15 - 24		Age 25 - 44		Age 45 - 64		Age 65 - 74		Age 75 +	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group I Infectious & Parasitic Diseases																
A41	Other septicaemia	0	3	0	0	0	0	0	0	0	0	0	0	0	1	0	2
	Totals Group I	0	3	0	0	0	0	0	0	0	0	0	0	0	1	0	2
	Group II Neoplasms																
C06	Malignant neoplasm of other and unspecified parts	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C15	Malignant neoplasm of oesophagus	5	4	0	0	0	0	0	0	0	0	1	0	3	0	1	4
C16	Malignant neoplasm of stomach	4	1	0	0	0	0	0	0	0	0	0	0	1	0	3	1
C18	Malignant neoplasm of colon	6	13	0	0	0	0	0	0	0	0	2	2	1	0	3	11
C19	Malignant neoplasm of rectosigmoid junction	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
C20	Carcinoma of the Rectum	5	3	0	0	0	0	0	0	0	0	1	1	2	1	2	1
C24	Maligt neoplasm of other and unspec parts biliary	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C25	Malignant neoplasm of pancreas	4	2	0	0	0	0	0	0	0	0	0	0	1	1	3	1
C26	Malignant neoplasm of other and ill-defined diges	3	1	0	0	0	0	0	0	0	0	2	0	0	0	1	1
C32	Malignant neoplasm of larynx	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C34	Malignant neoplasm of bronchus and lung	16	11	0	0	0	0	0	0	0	1	4	3	4	3	8	4
C43	Malignant melanoma of skin	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
C45	Mesothelioma	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
C46	Kaposi's sarcoma	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C50	Malignant neoplasm of breast	0	17	0	0	0	0	0	0	0	2	0	5	0	5	0	5
C51	Malignant neoplasm of vulva	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C53	Malignant neoplasm of cervix uteri	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	c/f	48	58	0	0	0	0	0	0	0	3	12	13	15	11	21	31

7.3 continued

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total		Under 1		Age 1 - 14		Age 15 - 24		Age 25 - 44		Age 45 - 64		Age 65 - 74		Age 75 +	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	b/f	48	58	0	0	0	0	0	0	0	3	12	13	15	11	21	31
C55	Carcinoma of Uterus	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C56	Carcinoma of the Ovary	0	8	0	0	0	0	0	0	0	0	0	3	0	2	0	3
C61	Carcinoma of the Prostate	7	0	0	0	0	0	0	0	0	0	0	0	0	0	7	0
C64	Malignant neoplasm of kidney	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C66	Malignant neoplasm of ureter	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C65	Malignant neoplasm of renal pelvis	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
C67	Malignant neoplasm of bladder	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C71	Malignant neoplasm of brain	2	1	0	0	0	0	0	0	0	0	1	1	1	0	0	0
C73	Malignant neoplasm of thyroid gland	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
C76	Malignant neoplasm of other and ill-defined sites	3	4	0	0	0	0	0	0	0	0	0	2	1	0	2	2
C78	Sec malignant neoplasm of respiratory and digesti	0	6	0	0	0	0	0	0	0	0	0	0	0	0	0	6
C79	Secondary malignant neoplasm of other sites	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0
C80	Malignant neoplasm without specification of site	2	2	0	0	0	0	0	0	0	0	0	1	0	0	2	1
C83	Diffuse non-Hodgkin's lymphoma	2	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
C90	Multiple myeloma and malignant plasma cell neopla	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
C91	Lymphoid leukaemia	1	2	0	0	0	0	0	0	1	0	0	0	0	0	0	2
C92	Myeloid leukaemia	3	0	0	0	0	0	0	0	0	0	1	0	0	0	2	0
C93	Monocytic leukaemia	2	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
	Totals Group II	75	85	0	0	0	0	0	0	1	3	16	20	21	13	37	49

7.3 continued

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total		Under 1		Age 1 - 14		Age 15 - 24		Age 25 - 44		Age 45 - 64		Age 65 - 74		Age 75 +	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group III Diseases of blood & blood-forming organs & certain disorders involving the immune mechanism																
D45	Polycythaemia rubra vera	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
D46	Myelodysplastic syndromes	1	1	0	0	0	0	0	0	0	0	0	0	1	1	0	0
	Totals Group III	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1
	Group IV Endocrine, nutritional & metabolic diseases																
E11	Non-insulin-dependent diabetes mellitus	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
E13	Other specified diabetes mellitus	3	0	0	0	0	0	0	0	0	0	0	0	1	0	2	0
E14	Unspecified diabetes mellitus	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
E66	Obesity	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
E86	Volume depletion	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
	Totals Group IV	4	5	0	0	0	0	0	0	0	0	0	0	1	0	3	5
	Group V Mental & behavioural disorders																
F00	Dementia in Alzheimer's disease	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
F03	Senile Dementia	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
	Totals Group V	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	4

7.3 continued

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total		Under 1		Age 1 - 14		Age 15 - 24		Age 25 - 44		Age 45 - 64		Age 65 - 74		Age 75 +	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group VI Diseases of the nervous system																
G11	Hereditary ataxia	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
G12	Spinal muscular atrophy and related syndromes	0	4	0	0	0	0	0	0	0	0	0	0	0	1	0	3
G20	Parkinsons Disease	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1
G40	Epilepsy	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Totals Group VI	2	7	0	0	0	0	0	0	0	0	0	1	0	2	2	4
	Group IX Diseases of the circulatory system																
I08	Multiple valve diseases	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
I09	Other rheumatic heart diseases	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I10	Essential (primary) hypertension	1	1	0	0	0	0	0	0	0	0	0	0	1	0	0	1
I11	Hypertensive heart disease	1	3	0	0	0	0	0	0	0	0	1	0	0	1	0	2
I21	Acute myocardial infarction	23	14	0	0	0	0	0	0	0	0	2	0	5	6	16	8
I25	Chronic ischaemic heart disease	33	31	0	0	0	0	0	0	1	0	4	1	8	4	20	26
I28	Other diseases of pulmonary vessels	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I34	Nonrheumatic mitral valve disorders	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	3
I35	Nonrheumatic aortic valve disorders	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
I42	Cardiomyopathy	1	2	0	0	0	0	0	0	0	1	0	0	0	0	1	1
I48	Atrial fibrillation and flutter	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
I50	Heart failure	7	15	0	0	0	0	0	0	0	0	0	0	1	1	6	14
I61	Intracerebral haemorrhage	9	10	1	0	0	0	0	0	0	0	1	2	3	3	4	5
I63	Cerebral infarction	2	2	0	0	0	0	0	0	0	0	0	0	0	1	2	1
	c/f	78	85	1	0	0	0	0	0	1	1	8	4	18	16	50	64

7.3 continued

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total		Under 1		Age 1 - 14		Age 15 - 24		Age 25 - 44		Age 45 - 64		Age 65 - 74		Age 75 +	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	b/f	78	85	1	0	0	0	0	0	1	1	8	4	18	15	50	64
I64	Stroke (or Cerebrovascular accident)	3	20	0	0	0	0	0	0	0	0	0	0	1	0	2	20
I67	Other cerebrovascular diseases	3	9	0	0	0	0	0	0	0	1	0	1	0	2	3	5
I70	Atherosclerosis	15	12	0	0	0	0	0	0	0	0	2	1	2	1	11	10
I71	Aortic aneurysm and dissection	5	5	0	0	0	0	0	0	0	0	1	0	2	1	2	4
I73	Other peripheral vascular diseases	2	4	0	0	0	0	0	0	0	0	0	0	1	0	1	4
I82	Other venous embolism and thrombosis	2	7	0	0	0	0	0	0	0	0	0	1	0	1	2	5
	Totals Group IX	108	142	1	0	0	0	0	0	1	2	11	7	24	20	71	112
	Group X Diseases of the respiratory system																
J03	Acute tonsillitis	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
J10	Influenza due to identified influenza virus	0	3	0	0	0	0	0	0	0	0	0	0	0	1	0	2
J11	Influenza	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
J18	Pneumonia	10	39	0	0	0	0	0	0	0	0	0	1	1	3	9	35
J42	Chronic Bronchitis	2	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0
J43	Emphysema	3	2	0	0	0	0	0	0	0	0	0	0	0	1	3	1
J44	Other chronic obstructive pulmonary disease	10	6	0	0	0	0	0	0	0	0	0	1	3	0	7	5
J47	Respiratory Failure	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
J84	Other interstitial pulmonary diseases	4	3	0	0	0	0	0	0	0	0	1	0	0	0	3	3
	Totals Group X	31	54	0	0	0	0	1	0	0	0	1	3	5	5	24	46

7.3 continued

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total		Under 1		Age 1 - 14		Age 15 - 24		Age 25 - 44		Age 45 - 64		Age 65 - 74		Age 75 +	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group XI Diseases of the digestive system																
K23	Disorders of oesophagus in diseases classified el	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K26	Duodenal ulcer	1	1	0	0	0	0	0	0	0	0	0	0	0	1	1	0
K27	Peptic ulcer	2	1	0	0	0	0	0	0	0	0	0	0	0	0	2	1
K44	Diaphragmatic hernia	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
K55	Vascular disorders of intestine	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
K56	Paralytic ileus and intestinal obstruction withou	0	2	0	0	0	0	0	0	0	0	0	1	0	0	0	1
K57	Diverticular disease of intestine	2	2	0	0	0	0	0	0	1	0	0	0	0	0	1	2
K63	Other diseases of intestine	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
K65	Peritonitis	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
K70	Alcoholic liver disease	1	3	0	0	0	0	0	0	1	1	0	0	0	1	0	1
K74	Fibrosis and cirrhosis of liver	3	1	0	0	0	0	0	0	0	0	3	1	0	0	0	0
K81	Cholecystitis	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
K92	Other diseases of digestive system	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Totals Group XI	14	14	0	0	0	0	0	0	2	1	3	2	2	2	7	9
	Group XIII Diseases of the musculoskeletal system & connective tissue																
M06	Other rheumatoid arthritis	1	1	0	0	0	0	0	0	0	0	0	0	0	0	1	1
M88	Paget's disease of bone [osteitis deformans]	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0
	Totals Group XIII	1	2	0	0	0	0	0	0	0	0	0	1	0	0	1	1

7.3 continued

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total		Under 1		Age 1 - 14		Age 15 - 24		Age 25 - 44		Age 45 - 64		Age 65 - 74		Age 75 +	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group XIV Diseases of the genitourinary system																
N05	Unspecified nephritic syndrome	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
N17	Acute renal failure	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
N18	Chronic renal failure	3	1	0	0	0	0	0	0	0	0	0	0	0	0	3	1
N30	Cystitis	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
N85	Other noninflammatory disorders of uterus	0	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0
	Totals Group XIV	6	2	0	0	0	0	0	0	0	0	0	0	1	1	5	1
	Group XVI Certain conditions originating in the perinatal period																
P02	Fetus and newborn affect comps placenta cord and	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Totals Group XVI	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
	Group XVII Congenital malformations of the nervous system																
Q01	Encephalocele	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0
Q06	Other congenital malformations of spinal cord	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Q20	Congenital malformations of cardiac chambers and	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
	Totals Group XVII	2	1	1	1	0	0	0	0	0	0	0	0	0	0	1	0

7.3 continued

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total M	Total F	Under 1 M	Under 1 F	Age 1 - 14 M	Age 1 - 14 F	Age 15 - 24 M	Age 15 - 24 F	Age 25 - 44 M	Age 25 - 44 F	Age 45 - 64 M	Age 45 - 64 F	Age 65 - 74 M	Age 65 - 74 F	Age 75 + M	Age 75 + F
	Group XVIII Symptoms, signs & abnormal clinical & laboratory findings, not elsewhere classified																
R54	old age (senility)	5	7	0	0	0	0	0	0	0	0	0	0	0	0	5	7
R95	Sudden infant death syndrome	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
R99	Other ill defined and unspecified causes of morta	5	7	0	0	0	0	0	0	0	0	0	0	0	0	5	7
	Totals Group XVIII	11	14	1	0	0	0	0	0	0	0	0	0	0	0	10	14
	Group XIX Injury, poisoning & certain other consequences of external causes																
S72	Fracture of femur	1	2	0	0	0	0	0	0	0	0	0	0	0	0	1	2
T51	Toxic effect of alcohol	2	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0
T68	Hypothermia	1	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0
	Totals Group XIX	4	2	0	0	0	0	0	0	0	0	2	0	1	0	1	2

7.3 continued

Guernsey - Deaths by ICD 10 Code and Age Groups 1996

ICD10 Code No.	Cause of Death	Total		Under 1		Age 1 - 14		Age 15 - 24		Age 25 - 44		Age 45 - 64		Age 65 - 74		Age 75 +	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
	Group XX External causes, morbidity & mortality																
V99	unspecified transport accidents	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
W19	Unspecified fall	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0
W68	Drowning and submersion following fall into swimming	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
W69	Drowning and submersion while in natural water	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0
W70	Drowning and submersion following fall into natur	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
X08	Exposure to other specified smoke	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
X60	Int sf pois/expo nonopioid analgesics, antipyretics	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
X61	Int sf pois/expo ant-epi sed-hyp ant park & psy't	0	2	0	0	0	0	0	0	0	1	0	0	0	0	0	1
X65	Intentional self-poisoning by and exposure to alc	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0
X67	Intent self-poisoning by and expos to oth gases a	3	0	0	0	0	0	0	0	2	0	1	0	0	0	0	0
X69	Intent self-poison/expos oth and unspec chems and	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0
	Totals Group XX	11	3	1	0	0	0	1	0	7	2	1	0	0	0	1	1
	Total Deaths:	**272**	**339**	**5**	**1**	**0**	**0**	**3**	**0**	**11**	**8**	**35**	**34**	**56**	**46**	**162**	**250**

7.4 Alderney Vital Statistics

	Males	Females	Total 1996	Total 1995
Population (1991 Census):	1023	1124	**2147**	2297
• **M : F**			**0.91**	0.93
Births - In Guernsey:	10	8	**18**	22
- Outside marriage:	2	1	**3**	5
Births - In Alderney:	0	0	**0**	0
Total Births to Alderney Residents:	10	8	**18**	22
Marriages Registered in Alderney:			**7**	7
Deaths Registered in Alderney:	11	18	**29**	33
Natural Increase:		(-0.5%)		

8.0 STAFF PROVIDING PUBLIC HEALTH SERVICES 1996

Director of Public Health/Medical Officer of Health
Dr David Jeffs MB MRCP MFPMM FRACGP FAFPHM DCH DObst RCOG FRSH

Personal Assistant
Mrs Maureen Indge

Data Clerk
Mrs Carol Gaskell

Part-time Medical Staff:

Deputy Medical Officer of Health
Dr Brian Parkin MB BS BSc MRCP MRCGP DRCOG

Sexual HealthClinic
Dr Nicholas King LRCP MRCS MBBS

Environmental Health Department:

Chief Environmental Health Officer
Mr Michael Bairds MCIEH MRIPHH FRSH

Deputy Chief Environmental Health Officer
Mr John Cook MCIEH

Environmental Health Officers
Mr Stan Horton MCIEH
Mr Tony Rowe MCIEH
Mr Stuart Wiltshire MCIEH
Mr Stephen Smith MCIEH (Part 1996)
Mr Jonathan Coyde MCIEH (Part 1996)

Trainee Waste Regulation Officer
Mr Simon Penney BSc (Hons) Grad M Inst WM

Pest Control Operatives
Mr Peter Durham (1996)
Mr Paul Tostevin
Mr Michael Brache (1997)

Secretary
Mrs Marilyn Bougourd

Health Promotion Unit:

Health Promotion Officer
Miss Yvonne Le Page BEd(Hons) DipHE&HP RHPS

Assistant Health Promotion Officer
Mrs Gerry Grange RGN LAY Trainer RHPS

Resources Officer
Mrs Pat Prevel

Secretary
Mrs Diana Reade

Occupational Health:

Clinical Medical Officer
Dr Helen Gibson MB BS MRCOG (until January 1996)
Dr Ian Gee MB BS MRCGP (from February 1996)

Occupational Health Nurse
Mrs Pam Smith RGN OHN

Fire, Health and Safety Officer
Mr Mark Guilbert